Assessment of decision-making capacity in patients requesting assisted suicide

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Abstract: In this editorial, we argue that current attitudes toward terminally ill patients are generally too paternalistic, and that it is wrong to assume that patients suffering from mental health issues (including depression) cannot consent to assisted suicide.

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Abstract: In this editorial, we argue that current attitudes towards terminally ill patients are generally too paternalistic, and that it is wrong to assume that patients suffering from mental health issues (including depression) cannot consent to AS.

Most countries that permit AS do so only for terminally ill patients. In Switzerland, Belgium, the Netherlands, and Luxemburg however, the law is more permissive: AS is permitted independently of life expectancy, which means those patients suffering from severe mental illnesses such as treatment-refractory major depressive disorder, treatment-resistant chronic schizophrenia, or severe persistent anorexia nervosa can also avail themselves of AS (or euthanasia, except in Switzerland). This more liberal legislation does, however, require that patients be of sound mind, and have the decision-making capacity (DMC) to consent to or request AS.

Four criteria for medical DMC are widely accepted[1]: (a) the ability to understand the relevant information, (b) the ability to appreciate the disorder and the medical consequences of the situation, (c) the ability to reason about treatment choices, and (d) the ability to communicate a choice.

The controversy surrounding DMC evaluations in patients seeking AS is due to the controversial nature of AS itself. Because it is unusual for doctors to be involved in deliberately ending a patients a life, and because of the irreversibility of the decision, some believe that a higher standard of competence should be demonstrated in order to ascribe DMC to the patient[2]. Thus, the stringency of DMC requirements should increase in proportion to the potential risk to the patient.[3] Some critics have even suggested that a request for AS is itself suggestive or even indicative of a lack of DMC.[4] Given these fundamental disagreements, it is hardly surprising that there is considerable variation in experts' opinions regarding proposed threshold of DMC, the required time frame to prove that a request for AS is stable and settled, and whether/how many different doctors must certify DMC. In a 2000 survey, 58% of psychiatrists claimed that major depressive disorder means that a patient is de facto incompetent.[5] This is unfortunate, as mental illness or cognitive dysfunction do not in themselves indicate that a patient lacks DMC.[1] Many mental and cognitive conditions are compatible with having DMC, and a patient can have depressive disorder without lacking DMC. A recent systematic review concluded that depression *can* influence DMC, not that it always does so.[6]

It appears that the DMC evaluation in AS is often affected by a sort of ethical contamination, with relatively simple cases of terminally ill patients requesting AS being conflated with more challenging cases of AS requests from patients who are not terminally ill; in addition, patients in both these categories may also have a psychiatric disease, making four categories in total. It is important to bear in mind that all four categories could include both competent and incompetent patients. Indeed, one of the reasons why standards are often set so high for those who are terminally ill but have no mental health issues is that concerns about DMC and lack of terminal illness can contaminate and infect discussions of even 'simple' requests for AS. One reason for this might be that it is not always obvious which category a patient will fall into.

We should prevent incompetent patients from harming themselves; in this case the harm would consist in helping them end their lives when they are not fit to make such a decision. The principle of respect for autonomy tells us that we should not prevent patients who are capable of making autonomous decisions from accessing AS if they wish to do so. Similarly, the principle of non-maleficence indicates that we should not inflict harm upon competent patients by insisting that they remain alive and suffering. More generally, the principle of justice prohibits unfair discrimination, and a DMC evaluation that stops competent patients from accessing AS would be unjust. As Schuklenk and Van de Vathorst have stated, "Erring on the side of caution… would imply also to let a fair number of patients suffer."[7]

All of these arguments are particularly applicable to the context of terminally ill patients who wish to access AS, for two main reasons. First, their autonomy should be respected; most such patients are no more likely to be incompetent than other patients of a similar age (in contrast, those who seek suicide in the absence of terminal illness raise more concerns regarding autonomy). Second, the potential harm of lost time alive to them is less than for patients who are not terminally ill; they are relatively close to death and simply want to avoid the potentially immense suffering in the last few months of their life. A contrasting argument might be that terminally ill patients will not suffer for very long, and that caution is therefore justified. However, the counter-objection is that caution is more important in cases where the patient is not terminally ill, and the consequent loss of life will be greater. In the case of terminally ill patients, they will not lose much life if they are granted AS, but they will avoid great suffering. The harms of unjustified AS are also great;

patients without DMC should not be able to access it, in case their decision would be different if they had DMC. But the threshold for justification should not be unreasonably high.

One way in which the bar is sometimes set too high for patients who are trying to access AS is by broadening the scope of DMC evaluations too far beyond issues of DMC. One example of this is using an inappropriately high standard of "stability" of attitudes, in line with the criteria of the Swiss Academy of Medical Sciences which mention that a patient's wish must persist over time. In principle, a patient can be competent and still be ambivalent about a wish. This can result in instable and changing requests over time in a competent patient. However, unstable attitudes can also be the consequence of fluctuating cognitive and voluntative mental capacities[8]. This shows that it is important to be more specific about DMC evaluations in terminally ill patients and to explain in more detail what should be evaluated. Otherwise, doctors opposed to AS could insist that a long period of time passes before AS can be provided to a terminal patient with early-stage dementia (for example). If the period is too long, the patient will either have already died or no longer pass a DMC evaluation at the end of it because his or her disease will have progressed. Because of these considerations, the degree of required stability should be reasonably proportional to the length of time before death, and should take into account the previous expressed attitudes of a patient. If someone has always been strongly autonomous and previously mentioned the intention to avoid suffering at the end of life, there is no reason to wait for another three weeks of stable wishes following a request for AS; one week could be enough. But in case where the patient had not expressed strong pro-autonomy views or had previously changed his or her mind about AS, it would be prudent to re-evaluate stableness more often and for a longer period.

Another issue is coercion. To find an example of a case where concerns about voluntariness and coercion ‚contaminated' DMC evaluations, one need look no further than Local Authority v Z., where an English welfare authority attempted to prevent a woman travelling to Switzerland to seek AS. In this case, she was found competent, but it was stated that she might have been found incompetent if she could not „assimilate the issues, or fully appreciate the consequences" or if she was „unduly influenced by the views of others or by undue concern for the burden that her condition imposed on others".[9] The first quote does concern DMC, but the second does not; undue influence concerns coercion, and the ‚burden' argument also relates

to questions about voluntariness. It would be a mistake if a patient were diagnosed incompetent purely on these latter grounds. Of course, if coercion is indeed present, AS should not be provided, but this example illustrates how other “excuses” can creep into what should be a narrow evaluation of DMC.

In some cases, of course, concerns about coercion are very closely linked to concerns about DMC, and about stability; for example, someone who technically meets DMC criteria might nonetheless feel under some pressure because of the financial strain he or she is placing on the family; if combined with a relatively unstable wish for AS, doctors might be correct to be concerned about DMC, all things considered. The interrelatedness of these concepts makes it quite easy for doctors opposed to AS to make excuses for not granting requests, and care must be taken to keep these concepts separate whenever possible.

Any doctor who attempts to prevent a competent patient from accessing AS is adopting an over-paternalistic stance that is contrary to the emphasis on autonomy in biomedical ethics more generally. One might never choose AS for oneself, or might think that the practice itself is deeply unethical, but to impose those values on one’s patients is deeply unethical and unprofessional.

In terms of specific rules, we recommend that physicians should use the approach summarised in Table 1.

DMC evaluations in patients requesting AS can be complex, but our analysis shows that some doctors may be exaggerating the complexity of it in some cases. For patients at the end of life, DMC evaluations should be relatively straightforward, even if they have mental health issues. For those who are not yet at the end of life, evaluating DMC can be more difficult and a higher standard may be justified, but care must be taken to avoid letting other considerations contaminate the DMC evaluation. Most importantly, doctors should not let any personal qualms about AS to infect the objectivity of DMC evaluation.

Table 1 – Recommendations for assessment of DMC in AS requests

- DMC should be presumed, except in young children and patients suffering from psychiatric diseases to the extent and of a type that interferes with DMC
- General evaluation should look for “red flags” suggesting lack of DMC

- General evaluation does not need to use systematic evaluation tools or instruments, but should document in a narrative way the required elements
- Evaluation (both general and enhanced) should adopt a proportional concept of stability of wishes which is derived from the patient's existing and previous attitudes. Therefore, the duration of the necessary "waiting period" will vary between patients.
- Doctors who have deep moral objections to AS should invoke conscientious objection and remove themselves from the process rather than trying to impose their views on patients.

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